AMAZING WELLNESS & CHIROPRACTIC

Good Faith Estimate for Amazing Wellness and Chiropractic Practice Members

Chiropractic New Patient Special: $99

Consultation, Evaluation, Examination, Xray of AOC, and First Adjustment

Chiropractic Adjustments

1-2 Region Adjustment: $50
3-4 Region Adjustment: $60
5+ Region Adjustment: $70

Extremity/Jaw Adjustment: $30
Extremity/Jaw Adjustment w/adj: $10 add.
Wellness Adjustment: $60
Pediatric Adjustment: $60

IASTM or other soft tissue therapies/techniques: $45 -or- $10 add-on w/an Adjustment

Laser Therapy as a standalone service: $60

Decompression New Patient Special: $99

Consultation, Evaluation, Examination, Xray of AOC, and first Decompression Session

Single Decompression Session*: $125

*Discounted Packages Available: See Decompression Therapy Form

Chiropractic Physicians reserve the right to adjust extremities during the session if they feel it will generate better results. If an extremity is adjusted during your session it will result in a $ 10.00 charge.

I, _____, acknowledge the receipt of this itemized list of services and all of the associated charges for the services stated above. I understand that I am responsible for any and all charges accrued on my account regardless of my insurance status.

This good faith estimate shows the cost of items and services that are reasonably expected for your health care needs. The good faith estimate does not include any unknown or unexpected costs that may arise during your care plan or while you are under care here at Amazing Wellness and Chiropractic, LLC. Prices are subject to change at any time the discretion of the owners and operators of Amazing Wellness and Chiropractic, LLC.

_____ Date: _____

Printed Patient Name

_____ _____

Patient Signature **Doctor Signature**

***This office does run on time. If you are 10 minutes late, please expect for your appointment to be rescheduled. We do our best to respect your time and in turn we ask that you do your best to respect our time and our other patients' time.**

Amazing Wellness and Chiropractic
13800 Tamiami Trail N. #113
Naples, FL 34110 **(239) 880-CARE** **info@AmazingWellness.com**
Updated: 3/14/2023

Amazing Wellness and Chiropractic New Patient Paperwork

Date:
HR#:

Chiropractic Neuropathy Decompression

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Birth date: _____ **Age:** _____ **Sex:** M F Single Married Widowed

Address (street, city, state, zip code)**:**

_____

Email: _____ **Phone Number:** _____ cell home

Occupation: _____ **Where/whom did you learn about our office from?** _____

In case of an emergency, who should we contact?

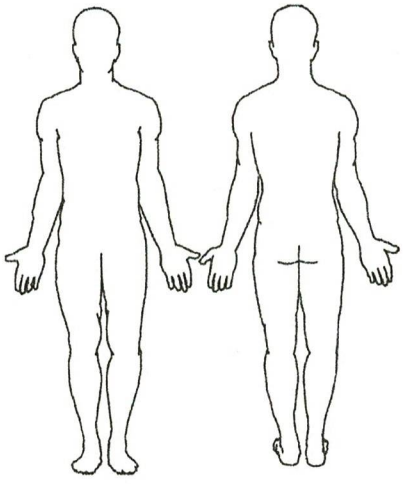
Name: _____ **Relationship:** _____ **Phone Number:** _____

Reason for visit: _____

Is this related to an auto or work accident? Yes No

When did your symptoms start? _____

Is the condition getting progressively worse? Yes No Consistent



*Mark an **X** on the picture where you continue to have pain, numbness, or tingling*

Rate the severity of your pain **right now** on a scale from **0** (no pain) **to 10** (severe pain) _____

Type of Pain:

☐ Sharp	☐ Throbbing	☐ Aching
☐ Burning	☐ Cramps	☐ Swelling
☐ Dull	☐ Numbness	☐ Shooting
☐ Tingling	☐ Stiffness	☐ Other: _____

How often do you have this pain? _____

Is it consistent or does it come and go? _____

Does it interfere with your ☐ work ☐ sleep ☐ daily routine ☐ recreation

Activities or movements that are painful to perform ☐ sitting ☐ standing ☐walking ☐ bending ☐ lying down ☐ sleeping

What treatments have you already received for this condition?

☐ medication ☐ surgery ☐ physical therapy ☐ chiropractic ☐ none ☐ other: _____

Name and phone number(s) of other doctor(s) who have treated this condition:

_____

Have you had any recent imaging done in relation to this condition? (within 1 year) X-ray MRI None

Date:
HR#:

Past Medical History

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsilitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

Exercise Habits: ☐ None ☐ Light ☐ Moderate ☐ Daily

Work Activity: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

Do you:	**How much/why?**
☐ Smoking	Packs/Day_____
☐ Alcohol	Drinks/Week ____
☐ Coffee/Caffeine	Cups/Day _____
☐ High Stress Level	Reason _____

Medications:_____

_____

_____

_____

_____

Supplements/Vitamins/Herbs/Minerals:

_____

_____

_____

_____

Injuries/Surgeries you have had:	**Description** (where and how)	**Date**
☐ Falls:	_____	_____
☐ Head injuries:	_____	_____
☐ Broken Bones:	_____	_____
☐ Dislocations:	_____	_____
☐ Surgeries:	_____	_____

Females Only

Are you currently pregnant? ☐ Yes ☐ No

Estimated Due Date: _____

# of pregnancies: _____

# of children and ages: _____

Date of Last Menstruation Cycle: _____

Printed Patient Name: _____

Patient Signature: _____

Date: _____

Doctor Signature: _____

Date: _____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain — **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain — **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

PATIENT'S NAME: _____ HR#: _____ DATE: _____

HIPAA Personal Health Information Release

I, _____, hereby authorize Amazing Wellness and Chiropractic to discuss with and/or release information to the following people concerning my appointments, insurance, billing, and health treatment rendered.

- O Spouse Name: _____
- O Significant Other Name: _____
- O Parent/Legal Guardian Name: _____
- O Child(ren) Name(s): _____
- O Any Specified Person Name: _____
- O Information is not to be discussed with or released to anyone.

Restrictions:

- O No Restrictions
- O Only discuss my appointment time with the above-named individual(s).
- O Only discuss issues concerning my account, including insurance and/or billing with the above-named individual(s).
- O Only discuss the health treatment rendered to me with the above-named individual(s).

Messages:

Please call O my home O my work O my cell phone
Phone Number: _____ - _____ - _____

If unable to reach me:

- O you may leave a detailed message
- O please leave a message asking me to return your call
- O _____

I understand I may terminate this consent at any time by giving written notice to Amazing Wellness and Chiropractic. Any changes to this form will require a new consent form to be completed, signed, and dated.

Signature: _____ Date: _____

PATIENT'S NAME: _____ HR#: _____ DATE: _____

Amazing Wellness and Chiropractic (Notice of Privacy Practice)

13800 Tamiami Trail North-Suite 113, Naples, FL 34110 239-880-2273
AmazingWellness.com info@amazingwellness.com

This office is required, by law, to maintain the privacy and security of your Protected Health Information. We must provide you with written notice concerning your rights to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to use and disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. Please review carefully, sign receipt of acknowledgement, and return to our front desk staff. **Keep this page for your records.**

YOUR RIGHTS:

1. To inspect or obtain a copy of your records within 15 days of your request. We may charge a reasonable, cost-based fee for a copy. X-rays are original records, and you are therefore not entitled to them. If you would like us to outsource them to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.
2. To ask for amendments to your health information you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. To request confidential communications (contact you in a specific way or send mail to a different address).
4. To request restrictions on certain uses and disclosures, and with whom we release information to, although we are not required to comply. If we do agree, the restriction is in place until receiving written notice of your intent to remove the restriction.
5. To receive an accounting of disclosures (those with whom we've shared your information).
6. To receive a paper copy of the extended detail Notice of Privacy Practices.
7. To choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
8. To file a complaint if you feel your rights are violated

USES AND DISCLOSURES:

1. Treatment purposes - use your health information and share it with other health care providers who are treating you.
2. Run our organization - use and share your health information to run our practice, improve your care, and contact you when necessary.
3. Bill for your services - use and share your health information to bill and get payment from health plans or other entities.
4. Inadvertent disclosures – an open treating area means open discussion. If you need to speak privately with the doctor, please let our staff know so we can place you in a private room.
5. Help with public health and safety issues - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. For health research purposes.
7. Comply with the law - share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. Work with a medical examiner or funeral director - share health information with a coroner, medical examiner, or funeral director in the event of a patient's death.
9. For workers' compensation claims, law enforcement purposes or with a law enforcement official, and other government requests – including health oversight agencies for activities authorized by law, special government functions such as military, national security, and presidential protective services.
10. Respond to lawsuits and legal actions - share health information about you in response to a court or administrative order, or in response to a subpoena.
11. Emergency – in the event of a medical emergency we may notify a family member.
12. Phone calls and/or emails – we may call your home and leave messages regarding appointment reminders or apprise you of changes in practice hours or upcoming events.
13. Change of ownership - in the event this practice is sold your health information will become the property of the new owner. You maintain the right to request copies of your health information be transferred to another provider.

COMPLAINT:

If you wish to make a complaint about how we handle your health information, please contact our privacy official using the information noted above. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

U.S. Dept. of Health and Human Services, Office of Civil Rights
200 Independence Avenue, SW, Washington DC 20201
877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

I hereby acknowledge I have read and received a copy of Amazing Wellness and Chiropractic Privacy Practices Notice.

I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practices" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware the practice will not use or share my information other than as described here unless I have provided written authorization stating otherwise. I understand I may change my mind at any time by providing written notification to the practice.

I am aware an extended detail version of this "Notice" is available to me upon request.

At this time, I do not have any questions regarding my rights or any of the information I have received.

Signature: _____ Date: _____

Print Name: _____ Witness: _____

Date:

AMAZING WELLNESS & CHIROPRACTIC

HR #:

About Health Insurance

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status.

I hereby authorize payment to be made directly to Amazing Wellness and Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Amazing Wellness and Chiropractic for any and all services I receive at this office.

Financial Policy

Please take a few moments to review the following information prior to your appointment.

We hope you understand that our financial policies are established to assure the financial resources needed to maintain this chiropractic office for all our patients and the services that they need and want. We will work to ensure that your chiropractic care does not become a financial burden.

Charges for services are due and payable between you and your health insurance status. We accept cash, personal checks, and credit cards for payment on your account.

Missed Appointment Policy

At Amazing Wellness and Chiropractic, we understand that life happens, however, due to necessity and appointment availability, we must respect all of our patient's time, as well as yours. Therefore, any appointment rescheduling must be done at least 24 hours prior to the scheduled appointment time.

If the patient fails to call and reschedule within the 24 hours of the scheduled appointment time and "no call no shows", a $20 missed appointment fee will be charged to the patient's account. The $20 missed appointment fee must be paid prior to any services being rendered.

Informed Consent

Regarding: Chiropractic Adjustments, Modalities & Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain type injuries, irritation of a disc condition, and although rare, minor fractures and possible stroke – which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Amazing Wellness & Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and/or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

***I have read and understand the above policies.**

_____

Patient Name (Printed)

_____ _____-_____-_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date Completed

Doctor's Signature: _____ Date: _____

Date: AMAZING WELLNESS CHIROPRACTIC HR #:

Female Only Informed Consent

Regarding: X-Rays/Imaging Studies:

Females Only: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, sere our front desk staff for further explanation.*

☐The first day of my last menstrual cycle was on_____-_____-_____ (Date)

☐I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor, and or a member of the staff, has discussed with me the hazardous effects of ionization to an unborn child and I have conveyed my understanding of the risks associated with exposure to x-ray. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

***I have read and understand the above policies.**

_____

Patient Name (Printed)

_____ _____-_____-_____ ☐ *Witness Initials*

Patient or Authorized Person's Signature Date Completed

Doctor's Signature: _____ Date: _____